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Patient Safety Culture as A Mediator Between Leadership and Incident Reporting

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ABSTRACT

This study investigates the influence of transformational leadership on patient safety incident reporting among nurses in the inpatient units of Charitas Group hospitals, with a focus on the mediating role of patient safety culture. Using a sequential explanatory mixed-methods design, the research integrates quantitative survey data from 232 nurses and qualitative insights from 16 key informants, including unit heads and safety committee leaders. Structural Equation Modeling and Sobel test results reveal that transformational leadership has a positive effect on patient safety culture but a paradoxically negative direct effect on incident reporting. Patient safety culture significantly mediates this relationship, underscoring the role of organizational climate in translating leadership into safety behaviors. Qualitative findings illuminate this paradox, revealing stark unit-level differences such as in the Pharmacy unit, where psychological safety and open dialogue are strongly fostered, while in other units, fear, silence, and inadequate follow-up persist. The study finds that institutional values are not consistently reflected in daily practices, limiting cultural transformation. This study contributes to the limited literature in Indonesia by highlighting how leadership must be embedded in safe and responsive environments to encourage safety behavior. Recommendations include strengthening leadership presence and follow-through, enhancing safety committee roles, and conducting routine audits to promote a just and learning culture. The findings provide actionable insights for hospital policy, leadership training, and efforts to improve organizational safety in healthcare settings.

Keywords
Hospital Organizational Climate
Incident Reporting
Mixed-Methods Research
Patient Safety Culture
Transformational Leadership

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Introduction

Unsafe care is a major global health issue, causing over 3 million deaths annually, with half resulting in permanent disability or death. Most harm—about two-thirds—occurs in low- and middle-income countries, especially in Africa and South Asia, with millions of adverse events each year. This not only strains resources but also damages public trust, healthcare workers' morale, and societal confidence in health systems. Improving safety practices could prevent half of this harm, saving over 3 million lives annually and promoting health equity worldwide [1].These figures highlight the urgency of strengthening patient safety practices and fostering a strong safety culture as an essential component of quality care delivery.

In Indonesia, this commitment is reinforced by Law No. 17 of 2023 on Health, which obliges all healthcare institutions to ensure patient safety and security. National guidelines, such as the 2015 National Guidelines for Hospital Patient Safety and the upcoming 2024 Guidelines for Patient Safety Culture Survey, provide a regulatory framework for risk identification, incident reporting, and organizational learning processes. These frameworks also encourage a shift from blame-oriented responses to more constructive, non-punitive approaches.

Charitas Group, a non-profit Catholic healthcare network operating six hospitals across Sumatra and Java conducts regular assessments of its safety culture using the Hospital Survey on Patient Safety Culture (HSOPSC 2.0). Results from the 2022–2023 survey indicate that key dimensions such as communication openness and non-punitive response to error scored only moderate to low. These findings point to persistent cultural and structural challenges that inhibit frontline nurses from reporting safety incidents without fear of negative repercussions.

In this context, leadership style has gained increasing attention as a key driver of safety outcomes. Transformational leadership, characterized by idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration, is widely recognized for fostering psychological safety, encouraging innovation, and strengthening team engagement [2], [3]. Evidence suggests that transformational leaders not only promote cultural change but also empower staff to report errors proactively, thereby supporting the development of a robust patient safety culture [4].

This study examines how transformational leadership affects nurses' incident reporting in Charitas Group inpatient units. It further explores the mediating role of patient safety culture in this relationship. As nurses are directly involved in patient care, their perceptions serve as crucial indicators of the organizational safety climate.

The novelty of this study lies in two aspects. First, it empirically examines the mediating role of patient safety culture, an area that remains underexplored in the context of Indonesian hospitals. Second, it employs a rigorous analytical approach, combining path analysis and Sobel testing to assess both direct and indirect effects. By focusing on inpatient units, where patient safety risks and interprofessional interactions are more complex, this research offers practical insights for hospital managers seeking to strengthen safety systems through leadership-based interventions.

The remainder of this paper is organized as follows. The next section presents the methodology, including study design, population, and instruments. This is followed by the results and discussion. The paper concludes with implications for hospital leadership and recommendations for policy, practice, and future research.

Literature Review

This study is based on several theories, including Organizational Behavior Theory, Donabedian's Quality of Care Model, and the Total Quality Management (TQM) approach. It examines how transformational leadership affects patient safety incident reporting through the role of patient safety culture. At the individual level, nurses' views and motivation to report incidents depend on organizational support and psychosocial factors [5],[6]. Donabedian's model highlights the essential role of structure and process in achieving good outcomes, with incident reporting being a vital part of quality care delivery [7]. In this context, TQM encourages ongoing improvement by involving all members of the organization in efforts to improve healthcare quality and patient safety, with support from leadership and active participation [8].

Transformational leadership is key in building a culture of safety through its main elements: idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration [2].A positive patient safety culture includes open communication, a non-punitive approach to errors, and supportive reporting systems that promote learning and teamwork [9], [10]. Nurses, who work directly with patients, play a crucial role in identifying and reporting risks early; however, their actions often depend on how much managerial support and a positive organizational climate they perceive [3], [11]. Therefore, this framework emphasizes the connection between leadership, system quality, and organizational culture, showing that incident reporting is not just a procedure but is part of complex social and institutional dynamics.

Material and Methods

A. Study Design and Setting

A sequential explanatory mixed methods design was employed for this study. This approach involved collecting and analyzing quantitative data first, followed by a qualitative phase to elaborate on and explain the initial quantitative findings. The study was conducted across six hospitals within the Charitas Group network in Indonesia. The research focused on nursing practitioners working in inpatient departments, as they are at the forefront of patient care and incident reporting.

B. Quantitative Phase: Data Collection and Analysis

In the quantitative stage, we distributed structured questionnaires to assess three primary constructs: transformational leadership, patient safety culture, and incident reporting behavior. The instruments were adapted from validated international scales and were tested for validity and reliability prior to the main study. A total of 232 nurses from the inpatient units participated in the survey.

Data analysis was performed using path analysis within a Structural Equation Modeling (SEM) framework with the AMOS software package (version 25). This allowed for the concurrent evaluation of the direct and indirect effects among the study variables. The Maximum Likelihood (ML) estimation method was used [12]. Furthermore, the Sobel test was employed to statistically verify the significance of the mediating role of patient safety culture.

C. Qualitative Phase: Data Collection and Analysis

Upon analyzing the quantitative results, we proceeded with a qualitative investigation to provide contextual depth and a nuanced understanding of the phenomena. Sixteen key informants were purposefully selected based on their comprehensive knowledge of patient safety incident reporting and ward-level leadership. The participants comprised ten Heads of Inpatient Wards and six Chairpersons of the Patient Safety Committee (PMKP).

Semi-structured interviews were conducted over the telephone, each lasting approximately 30 to 45 minutes. These interviews were designed to explore informants' experiences, perceptions, and the underlying reasons for the patterns observed in the quantitative data. All interviews were recorded and transcribed verbatim for analysis.

The qualitative data analysis followed a systematic, multi-stage approach guided by the interactive model of Miles and Huberman, which encompasses data reduction, data display, and conclusion drawing/verification. We began by extracting salient points from the transcripts (data reduction), which were then organized thematically using narrative and matrix presentations (data display). Finally, we interpreted the emergent patterns and interrelationships to build a coherent explanation [13].

To enhance the rigor and credibility of the qualitative findings, we employed several strategies. Source triangulation was achieved by incorporating perspectives from both ward heads and PMKP chairs, providing a more comprehensive view of the reporting infrastructure and safety ethos. Throughout the coding and analysis process, the researchers practiced reflexivity by maintaining reflective journals to critically examine and document how their professional backgrounds might influence data interpretation, thereby promoting analytical transparency [14].

Results

A. Respondent Characteristics

A total of 232 nurses from the inpatient units of six Charitas Group hospitals participated in the quantitative survey. As detailed in Table 1, the majority of respondents were female (86%), aged between 31 and 40 years (49%), and held a diploma-level nursing education (53%). In terms of professional experience, the largest group had been working for 10 to 20 years (39%), indicating a cohort of seasoned practitioners. Over half of the participants (56%) were from Charitas Hospital Palembang, reflecting its central role within the hospital network.

Table 1. Respondent Characteristics (n = 232)

Characteristic	n (232)	%
Gender		
• Male	33	14
• Female	199	86
Age		
• ≤30 years	78	33
• 31-40 years	113	49
• 41-50 years	39	17
• >50 years	2	1
Educational Background		
• Diploma-level nursing (D3)	122	53
• Bachelor's degree (D4/S1)	110	47
Years of Work Experience		
• 1-5 years	62	27
• > 5-10 years	52	22
• >10-20 years	91	39
• > 20 years	27	12
Hospital of Employment		
• Charitas Hospital Palembang	130	56
• Charitas Hospital KM7	38	16
• Charitas Hospital Belitang	32	14
• Charitas Hospital Kenten	15	7
• Charitas Hospital Arga Makmur	9	4
• Charitas Hospital Klepu	8	3

B. Validity and Reliability Tests

Based on the validity and reliability tests, most questionnaire items were confirmed to be both valid and reliable. Items that did not meet the required criteria were excluded from further analysis to ensure the accuracy of measurement and consistency of the instrument. The

analysis focused on three main variables: transformational leadership (X1), patient safety culture (M1), and patient safety incident reporting (Y1).

C. Respondents Perceptions

Table 2 presents respondents' perceptions of the research variables examined in this study. The table summarizes the distribution of responses for each variable based on the indicators measured through the research instrument. The data provide an overview of how respondents perceive and evaluate each variable, including the tendency of responses toward positive, moderate, or negative categories.

Table 2. Respondents' Perceptions of Variables

Variable	Average Score	Scale Range	Perception Characteristics
X1 (Transformational Leadership)	11.72	4-16	Good
M1 (Patient Safety Culture)	63%	0-100%	Moderate
Y1 (Incident Reporting)	3.47	1-5	Good

a. X1 is measured through 4 statement items with a 1–4 Likert scale. The total score ranges from 4 (low) to 16 (high). Interpretation: 4–7 = low; 8–11 = moderate; 12–16 = good
b. M1 is expressed as a percentage of the ideal score. Interpretation: <60% = low; 60–79% = moderate; ≥80% = high
c. Y1 was assessed using multiple statement items across different dimensions. Due to the unequal number of indicators per dimension, each item was evaluated using a Likert scale ranging from 1 to 5, and the average score was used to determine the perception category. The interpretation is as follows: 1.00–1.79 = Very Poor / Low; 1.80–2.59 = Poor / Low; 2.60–3.39 = Fair; 3.40–4.19 = Good / High; 4.20–5.00 = Very Good / High

Descriptive analysis provided insight into respondents' perceptions of the core variables. Transformational leadership (X1) was generally perceived positively, with an average score of 11.72 on a scale of 4-16. The patient safety culture (M1) variable received a moderate average score of 63%. A closer look at its dimensions revealed significant strengths in "Teamwork" (80%) and "Organizational Learning" (75%). However, critical areas such as "Staffing and Work Pace" (22%) and "Non-punitive Response to Error" (56%) were identified as major weaknesses. The incident reporting behavior (Y1) variable had a good average score of 3.47 (on a 1-5 scale), although the dimension of "Speaking Up" scored lower (2.85), suggesting room for improvement in staff confidence to voice safety concerns.

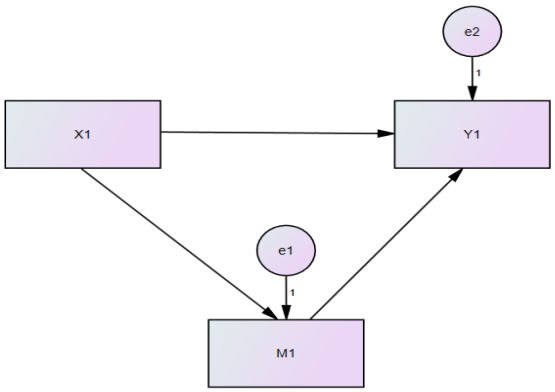
D. Path Analysis Results

Path analysis was conducted using AMOS on 223 datasets that met the normality assumption after data cleansing. The structural model (Fig. 1) and parameter estimates (Table 3) outline the relationships between the variables.

The analysis yielded three key direct effects:

1. Transformational leadership (X1) demonstrated a significant and positive influence on patient safety culture (M1) ($\beta = 0.415$, $p < 0.001$).
2. Patient safety culture (M1), in turn, had a strong positive and significant effect on incident reporting (Y1) ($\beta = 0.728$, $p < 0.001$).
3. A surprising and significant negative direct effect was found between transformational leadership (X1) and incident reporting (Y1) ($\beta = -0.115$, $p = 0.032$).

The indirect effect of transformational leadership on incident reporting, mediated through patient safety culture, was positive and significant (β = 0.302). This resulted in a positive total effect (β = 0.187), indicating that the overall influence of leadership on reporting is channeled predominantly through the cultivation of a safety culture.



Source: IBM SPSS AMOS 25

Fig. 1. Structural Model of Transformational Leadership, Patient Safety Culture, and Incident Reporting

Table 3. Estimated Parameters of Path Analysis

Path	X1 → M1 (a)	M1 → Y1 (b)	X1 → Y1 (Direct)	X1 → Y1 (Indirect)	X1 → Y1 (Total)
Unstandardized Coefficient (B)	0.692	0.400	-0.105	0.277	0.171
Standard Error (SE)	0.102	0.029	0.049	–	–
Critical Ratio (C.R.)	6.79	13.608	-2.15	–	–
P-value	***	***	0.032	–	–
Standardized Coefficient (Beta)	0.415	0.728	-0.115	0.302	0.187
Remarks	Significant	Significant	Significant (negative)	Significant	Significant

E. Sobel Test for Mediation

To confirm the significance of the mediating role of patient safety culture, a Sobel test was performed. The test yielded a Z-statistic of 6.089 ($p < 0.001$), providing robust statistical evidence that patient safety culture is a significant mediator in the relationship between transformational leadership and incident reporting.

F. Preliminary Qualitative Insights

An initial thematic analysis of the interviews with ward heads and safety committee chairs provided crucial context for the quantitative findings. A stark contrast was observed in the implementation of leadership and safety practices across different units. In high-performing units like the Pharmacy, transformational leadership was consistently embodied through daily safety briefings and open discussions of incidents, fostering psychological safety and a learning

culture. Conversely, in several nursing units, a persistent "culture of silence" was evident, particularly among junior staff. Key informants attributed this to fear of blame, hierarchical communication barriers, and perceptions that reporting incidents would not lead to constructive change but could negatively impact performance evaluations. These qualitative insights begin to explain the paradoxical negative direct effect, suggesting that leadership qualities, while perceived positively overall, are insufficient to overcome deep-seated cultural and psychological barriers to reporting in certain contexts.

Discussions

This study provides a nuanced understanding of the relationship between transformational leadership, patient safety culture, and incident reporting in Indonesian hospital settings. Our findings reveal a complex mediation model where patient safety culture serves as the crucial mechanism through which leadership influences reporting behaviors.

A. The Paradox of Transformational Leadership and Incident Reporting

The most intriguing finding of this study is the significant negative direct effect of transformational leadership on incident reporting (β = -0.115, p = 0.032). This appears counterintuitive given the extensive literature advocating transformational leadership's positive impact on safety behaviors [2], [15]. However, our qualitative data provides compelling explanations for this paradox.

The disparity in leadership implementation across units emerged as a critical factor. While the Pharmacy unit consistently applied transformational principles through daily safety briefings and open incident discussions [16], many nursing units struggled with persistent fear among junior staff. As one PMKP chair noted:

> *"Junior nurses are afraid because seniors once said that reporting could go into your performance record. This has become an inherited culture of silence"* (PMKP 6).

This suggests that inspirational leadership alone cannot penetrate deep-seated organizational fears and hierarchical barriers [17], [18].

Furthermore, we found that transformational leadership's effectiveness is contingent on psychological safety. As Feitelberg [19] emphasized, safety leadership requires active presence—not just inspiration. Our interviews revealed that many leaders were passive in follow-up, relying on top-down socialization rather than collaborative problem-solving. This created a gap between leadership rhetoric and daily practice, particularly affecting junior staff who reported feeling uncomfortable reporting incidents to leaders they perceived as distant or authoritative.

B. The Central Role of Patient Safety Culture

Our findings strongly support the mediating role of patient safety culture (β = 0.302, Sobel Z = 6.089, p < 0.001), aligning with Kim & Kwak's [20] assertion that safety culture enables

leadership values to be internalized into reporting behaviors. The quantitative data revealed a moderate overall safety culture score (63%), characterized by notable strengths in teamwork (80%) and organizational learning (75%)—a finding consistent with Tasbihi et al. [21], who demonstrated a positive correlation between teamwork, psychological safety, and safety competence among nurses. However, critical weaknesses were identified in non-punitive response to error (56%) and staffing adequacy (22%). These specific deficits illuminate the mechanics of the mediation; as Zabin et al. [22] explain, high workload stress impairs safety perceptions, while Alonazi et al. [23] observed that fear of being blamed remains a key barrier to incident reporting despite supportive teamwork.

Our qualitative findings confirm this dynamic in practice. In units where values like transparency and a non-punitive approach were consistently enacted, reporting was more robust. As one head nurse explained, "We discuss incidents openly in our briefings. It's not about blame—it's about shared improvement" (Head Nurse 5). This demonstrates that leadership practices successfully translate into reporting behaviors only when embedded within a cultural framework that actively mitigates fear and overload.

C. Systemic Barriers and the KASIH Values Reflection

Our study identified several systemic barriers that undermine reporting effectiveness. Workload pressures emerged as a significant factor, with nurses reporting that incident documentation felt like an additional burden without adequate recognition or time allocation. This aligns with Huang et al. [24], who emphasized that organizational support mechanisms, including workload management, are crucial for enabling safety practices.

The reflection on Charitas Group's KASIH values (*Komunikatif, Andal, Sinergis, Inovatif, Hangat*) revealed significant implementation gaps. While "Komunikatif" encourages openness, communication barriers persisted, especially among junior staff. The "Andal" principle, promoting reliability and accountability, was inconsistently enacted due to insufficient leadership follow-through after incident reports. These findings suggest that organizational values must be translated from aspirational statements into lived behaviors through systematic reinforcement and leadership modeling.

D. Theoretical and Practical Implications

Theoretically, this study contributes to the limited literature in Indonesia by empirically demonstrating the mediating role of patient safety culture using a robust mixed-methods design. Our findings support and extend the work of Abdalla et al. [25], who suggested that a psychologically safe culture is the crucial bridge through which leadership vision translates into concrete action.

Practically, the findings offer several actionable insights for hospital management:

1. Leadership development should focus on consistent implementation of transformational behaviors across all units, with particular attention to creating psychological safety for junior staff.
2. Patient safety initiatives must address systemic barriers, particularly staffing adequacy and non-punitive response systems.
3. The PMKP committee's role should be strengthened with adequate resources and authority to standardize safety practices across units.
4. Organizational values like KASIH need to be operationalized into specific, measurable behaviors with accountability mechanisms.

Conclusions

This study underscores the pivotal role of transformational leadership in shaping patient safety culture and, indirectly, improving incident reporting behavior among nurses in inpatient units of Charitas Group hospitals. While transformational leadership was positively associated with a stronger safety culture, its direct effect on reporting behavior was unexpectedly negative highlighting a paradox that warrants deeper reflection. The findings reveal that leadership practices alone are insufficient unless embedded in psychologically safe, structurally supportive environments.

The study successfully filled a knowledge gap in the Indonesian hospital context by empirically examining the mediating role of safety culture using a robust mixed-methods design. Insights from high-performing units, such as Pharmacy, illustrated that when leadership is consistently practiced and supported by open dialogue, learning from errors becomes part of the organizational habitus. In contrast, in nursing units with hierarchical constraints or fear of judgment, leadership influence was diluted. Thus, the study not only confirms the theoretical importance of safety culture as a mediating mechanism but also offers practical evidence that organizational culture can either amplify or undermine the impact of leadership interventions.

Limitations of the Study

While this study provides valuable insights, several limitations should be acknowledged. First, the research was conducted within a single hospital network (Charitas Group), which may limit the generalizability of findings to institutions with different organizational structures or cultural contexts. Second, the cross-sectional design prevents definitive conclusions about causality between the variables. Third, the use of self-reported data for incident reporting may be subject to social desirability bias, where respondents might underreport sensitive information. Finally, although anonymity was encouraged, the nature of

organizational hierarchy might have influenced response authenticity despite our methodological precautions.

Recommendations

A. For Research

Future studies should expand the research context across diverse hospital networks to enhance external validity. Longitudinal or experimental designs would help establish causal relationships more definitively. Incorporating objective measures of reporting behavior and employing multilevel modeling to account for unit-level variations would provide more nuanced understanding.

For Practice

Hospital management should focus on:

1. Developing leadership training programs that emphasize consistent implementation of transformational behaviors across all units, with special attention to creating psychological safety for junior staff
2. Strengthening the patient safety culture by addressing critical weaknesses in non-punitive response to error and staffing adequacy
3. Enhancing the role of PMKP committees through adequate resources and authority to standardize safety practices
4. Implementing routine safety audits and feedback mechanisms to reinforce a just culture
5. Aligning organizational values with daily practices through systematic monitoring and accountability systems

These recommendations provide actionable pathways for healthcare organizations to leverage leadership potential while addressing contextual barriers to patient safety improvement.

Conflict of Interest

The authors declare no conflict of interest.

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